

State of Illinois  
Department of Children and Family Services

INITIAL INQUIRY

Circle one:      Traditional                      Relative                      Child Specific                      ICPC

Name(s) of Potential Applicant(s)		Date of Birth	SSN Last 4 Digits	Email Address:		
A.						
B.						
Home Address		City		ZIP Code	Primary Phone Numbers	
				H:	C:	
Name(s) of Other Adults (17 and Older) Living in the Home	DOB	SSN Last 4 #s	Name(s) of Other Adults (17 and Older) Living in the Home		DOB	SSN- Last 4 #s
1.			3.			
2.			4.			
Name, Gender, and Age of Any Child under 17 Living in the Home:						
1.	/ /	2.	/ /	3.	/ /	
4.	/ /	5.	/ /	6.	/ /	

**Home:** Rent ☐ Own ☐ Number of Bedrooms Available for Fostering: \_\_\_\_ Number of Beds Available for Fostering: \_\_\_\_

**Language:** Speaks language(s) other than English? ☐ No ☐ Yes If yes indicate Language: \_\_\_\_\_  
Proficiency: Bilingual \_\_\_\_\_ Fluent \_\_\_\_\_ Conversational \_\_\_\_\_

**Discussed the Following:** Application Packet ☐: \_\_\_\_\_ Background Checks ☐: \_\_\_\_\_ Fingerprinting ☐ \_\_\_\_\_

Medicals/Health /TB tests ☐: \_\_\_\_\_ Source of Income ☐: \_\_\_\_\_ Pets ☐ (if any, please describe): \_\_\_\_\_

☐ Motivation for Fostering/Adoption: \_\_\_\_\_

☐ Special Needs/Sibling Groups/Teens/Age/Gender **Preference?** \_\_\_\_\_

**Information Resulted In:**

- ☐ Returned Call: \_\_\_\_\_ Date/Time \_\_\_\_\_  
☐ Appointment Scheduled: \_\_\_\_\_ Date/Time \_\_\_\_\_  
☐ Referred to Private Agency  
☐ Information Only  
☐ Caller will Call Back if Interested  
☐ Counseled Out

**Person Completing/ Source of Inquiry**

**Date/Time**

**Assigned to:**

**Foster Care Licensing Representative**

**Date**

**Use back for Additional Notes, PRIDE Referral Information, Final Status and/or Justification if Counseled Out.**

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Additional Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Application Received: Y or N (If yes, the date application opened) \_\_\_\_\_

SACWIS Check Applicant A – Date: \_\_\_\_\_ Finding: \_\_\_\_\_

SACWIS Check Applicant B – Date: \_\_\_\_\_ Finding: \_\_\_\_\_

Referred to PRIDE – Date: \_\_\_\_\_ Location: \_\_\_\_\_

Final Status of Application: \_\_\_\_\_

Justification for Counseling Out the Family (Licensing Issues, Other Reasons), when applicable: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

FDS Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Supervisor Signature: \_\_\_\_\_ Date: \_\_\_\_\_